updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under §447.78(a).

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30264, May 28, 2010]

§447.74 Alternative premium and cost sharing protections for individuals with family incomes above 150 percent of the FPL.

(a) States may impose premiums under the State plan consistent with the aggregate limits set forth in §447.78(a) on individuals whose family income exceeds 150 percent of the FPL.

(b) Cost sharing may be imposed under the State plan on individuals whose family income exceeds 150 percent of the FPL if the cost sharing does not exceed 20 percent of the payment the agency makes for the item or service (including a non-preferred drug but not including non-emergency services furnished in a hospital emergency department), with the following exception: In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed $3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI–U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate premiums and cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under §447.78(a).

[75 FR 30264, May 28, 2010, as amended at 75 FR 38749, July 1, 2010]

§447.76 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.

(2) Current cost sharing charges.

(3) The aggregate limit on premiums and cost sharing or just cost sharing.

(4) Mechanisms for making payments for required premiums and charges.

(5) The consequences for an applicant or recipient who does not pay a premium or charge.

(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.

(7) Either a list of preferred drugs or a method to obtain such a list upon request.

(b) The State must make the public schedule available to the following:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a State plan amendment (SPA) to establish alternative premiums or cost sharing under section 1916A of the Act or an amendment to modify substantially an existing plan for alternative premiums or cost sharing, the State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment in a form and manner provided under applicable State law, and must submit documentation with the SPA to demonstrate that this requirement was met.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30264, May 28, 2010]